MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01940

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Geotge's

City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 3 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4012 - 30th St. Mt. Ranier
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: WILLIAM H. ADAMS

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Barbara F. Adams (dec.)

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1894

8. AGE: Years	Months	Days	If less than one day
50	5	9	...hrs. ...min.

9. Birthplace: Ft. Gibson, Oklahoma
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: —

FATHER
12. Name: Richard C. Adams
13. Birthplace: Kansas

MOTHER
14. Maiden name: Carrie F. Meigs
15. Birthplace: Oklahoma

16. Informant: Decadent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/21/45 (month) (day) (year)

Cemetery or cremetory:

Location: Washington D. C.

18. Funeral director: The S. H. Hines Co.

Address: 2901-14th St. N.W.

19. Feb. 21 19 45 Rowland S. Phillips Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21, 1945, at 10 22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1945, to Feb 21, 1945 and that I last saw h... (A... alive on Feb 21, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1½ MO.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 2/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01941

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Gro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Gro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Louise Emily Leigear Astlin.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 3, 1945

8. AGE: Years | Months: 1 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Laurel Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Geo woodrow astlin
13. Birthplace: md

MOTHER
14. Maiden name: Gladis B. Leigear
15. Birthplace: md

16. Informant: Geo woodrow astlin
Address: Berwyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24 1945 (month) (day) (year)

Cemetery or crematory: Colesville
Location: " md

18. Funeral director: F. Gaschis Sons
Address: Hyattsville md

19. Feby 21st 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 22 1945, at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 20 1945 to 2 22 1945 and that I last saw her alive on 2 20 1945

Immediate cause of death: L Lobar pneumonia

	DURATION
	2 dys
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: B P Warren M. D. or other

Address: Laurel md Date signed 2 23 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01942

CERTIFICATE OF DEATH

Reg. Diat. No. 105-24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Accokeek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ years

Hospital, Institution, or street address where death occurred:

Livingston Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Accokeek

(If outside city or town limits, write RURAL and give nearest town)

Street No. Livingston Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leonard Martin Bailey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Frances Bailey

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 28, 1893

8. AGE: Years	Months	Days	If less than one day
51	8	26	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Auto mobile Mechanic

11. Industry or business

FATHER 12. Name Richard Bailey

13. Birthplace Virginia

MOTHER 14. Maiden name Hold Name

15. Birthplace Virginia

16. Informant Helen Frances Bailey

Address Accokeek, Md.

17. Burial Date thereof 2/26/45

(Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Natl

Location Mt Victory Arlington, Va.

18. Funeral director Hunter & Ryon

Address Waldorf, Md.

19. 2-24-45 M. L. Mark

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 45, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE James W. Lloyd M. D. or other

Address Waldorf, Md. Date signed 2-24-45

Evidence for change of age of deceased is shown on FILM No G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

01943

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3600 Perry St, Mt. Rainier
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Baker, Harry

3. (b) Social Security Number None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Mary Elizabeth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 9 1876.

8. AGE: Years	Months	Days	If less than one day
77 68	9	6	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name William Baker
13. Birthplace Md.

MOTHER
14. Maiden name Mary Parker
15. Birthplace Md.

16. Informant C. W. Baker
Address 5808 43rd ave Hyattsville, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB 6 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery
Location Colmar Manor Md
18. Funeral director F Gaecke sons
Address Hyattsville Md.

19. 2/6 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 3 1945 at 8:50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1944, to Jan. 3 1945
and that I last saw him alive on Jan. 3 1945

Immediate cause of death	DURATION
Primary Carcinoma of Bladder	6 mos.
Chronic Pulmonary Tuberculosis	
Due to with Tuberculosis Pneumonia	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles C. Hagaage M.D.
M. D. or other
Address Mt. Rainier, Md. Date signed Jan. 3 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01944

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 3 mos., 22 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 3 mon., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 H. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: HIPLITO BALASA

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1898

8. AGE: Years	Months	Days	If less than one day
46	9	8	hrs. min.

9. Birthplace: Manilla, Philippine Islands
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Jose Balasa
13. Birthplace: Philippine Islands

MOTHER
14. Maiden name: Catextro
15. Birthplace: Philippine Islands

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Feb 27-1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

19. Funeral director: James T. Ryan Inc

Address: 317 Penn Ave, S.E. Wash, D.C.

19. (Date rec'd by registrar) Feb. 26, 1945 Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26, 1945, at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4, 1941, to Feb. 26, 1945 and that I last saw him alive on Feb. 25 1945

Immediate cause of death	DURATION
Subacute Nephritis	2 mo 11 da
Pulmonary Tuberculosis	3 yrs 4 mo.
Complications:	
Due to:	
Other conditions: Cataract left eye	5 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Subacute nephritis, bilateral

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Pulmonary tuberculosis caseous tuberculosis

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

1945

Reg. Dist. No. 246

1. PLACE OF DEATH:

County Prince Georges

City or town Avondale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/4 years

Hospital, institution, or street address where death occurred: 1903 - Greens Chapel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Avondale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1903 - Greens Chapel Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Miller Barger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John H. Barger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19, 1873

8. AGE: Years	Months	Days	If less than one day
71	8	23	..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Adolph Miller

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Emma Geier

MOTHER 15. Birthplace Germany

16. Informant Frances Barger

Address 1903 Greens Chapel Rd, Avondale

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 15, 1945 (month) (day) (year)

Cemetery or crematory St Mary's Cemetery

Location Washington D.C.

18. Funeral director Francis Geiers Sons Co

Address 3605-14 St N W Wash, DC

19. Feb 13 1945 (Date rec'd by registrar) May E. Diner Dept Local Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945, at 6 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James D. Boyd M. D. or other

Address Forestville Md Date signed 2-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01946

(243)

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Md - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1928 - 12th, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: JAMES E. BOARMAN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (sep.)

6.(b) Name of husband or wife: Martha Norman

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1898

8. AGE:

Years	Months	Days	If less than one day
46	3	12	....hrs. ....min.

9. Birthplace: King George Co. Virginia (Town, county, and state)

10. Usual occupation: Messenger, Navy Dept.

11. Industry or business: —

FATHER

12. Name: Frank H. Boarman

13. Birthplace: Jeffersonville, Indiana

MOTHER

14. Maiden name: Lula Beverly

15. Birthplace: King George Co., Va.

16. Informant: deceased

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Feb. 7, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: Thos. F. Mangan Co.

Address: 389 - R.I. Ave. N.W.

19. Feb. 7 1945 (Date rec'd by registrar) Rowland S. Phillips Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7, 1945, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945 to Feb. 7 1945 and that I last saw him alive on Feb. 6, 1945.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	4 mo.
Due to:	
Complication: Right spontaneous pneumothorax and hydro-pneumothorax	10 days
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please noderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Penicare M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

01947 245

Reg. Dist. No. 239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. R 1 Box 111
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Boswell, Mrs Catherine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W.	married

6.(b) Name of husband or wife: Boswell, Mr. Earl.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 14, 1906.

8. AGE:	Years	Months	Days	If less than one day
	38	4	19	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business

FATHER 12. Name: Rose, Joseph F.

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Payne, Jeannette

MOTHER 15. Birthplace: Takoma Park, Md.

16. Informant: Mrs. Earl Boswell.

Address: R 1 Box 111 Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6-45 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md.

18. Funeral director: Lloyd Lanier

Address: Laurel Md.

19. Feb. 6 19 45 (Date rec'd by registrar) Cora E. Wadelton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 19 45 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 19 44 to Feb 2 19 45 and that I last saw h[illegible] alive on Feb 2 19 45

Immediate cause of death	DURATION
Carcinoma Lung	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E E Boswell M.D. or other

Address: Laurel Date signed: 2/8/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

01948

1. PLACE OF DEATH (No)

County Prince Georges Co. Registration Dist. No. 237

Village or City Aquasco No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 73 yrs. mos. ds. How long in U.S. if of foraign birth? yrs. mos. ds.

2. FULL NAME Dr. Henry Morton Bowen If U. S. Veteran, specify WAR

(a) Residence: No. Aquasco St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE OF~~ Bertha Lee Bowen.

6. DATE OF BIRTH (month, day, and year) April 4/1871

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	11	

OCCUPATION

8. Trada, profassion, or perticular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work wes dona, as SILK MILL, SAW MILL, BANK, etc. Physician

10. Date deceased last workad at this occupation (month and year)

11. Total time (yaars) spent in this occupation

12. BIRTHPLACE (city or town) Aquasco, Md.
(State or country)

FATHER

13. NAME Philander Adams Bowen

14. BIRTHPLACE (city or town) Washington D.C.
(State or country)

MOTHER

15. MAIDEN NAME Rachel C. Morton

16. BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

17. INFORMANT Mrs Henry B. Cooley
(Address) Aquasco Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ St. Mary Chapl. Cem.
Place Aquasco, Md. Date Feb. 19, 1945

19. UNDERTAKER Eugene C. Gingor
(Address) Aquasco Md.

20. FILED Feb. 18th, 1945 Mrs Henry B. Cooley
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. 15 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1941, 19, to Feb. 15, 1945

I last saw him alive on Feb. 15, 1945; death is said to hava occurred on tha date stated above, at 3 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance ware es follows:

	Date of onset
1. Coronary Thrombosis	2-11-45
2. Coronary Sclerosis	

Other Contributory Causes of importanca:

Coronary Thrombosis 1941
1942 - 1943

Name of oparation Data of

Whet test confirmed diegnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicida, or homicida? Date of injury, 19

Whera did injury occur? (Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury

Netura of injury

24. Was disease or injury in any way related to occupation of deceasad?

If so, specify

(Signed) Hugh D. Vansant M. D.

(Address) Aquasco, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01949 Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Geo. county
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8145 Baltimore Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. Bragg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1861

8. AGE:

Years	Months	Days	If less than one day
83	11	6	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Bragg, Edwin
13. Birthplace Md.
MOTHER 14. Maiden name ? Adelaide
15. Birthplace Md.
16. Informant Mrs. Ella Wolf
Address 8145 Balto. Blvd. Berwyn, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb 7 45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director Wm Cook
Address Baltimore Md.
19. Feb 7 1945 Amelia Dewey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 11:25 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 18 1945, to Feb 6 1945
and that I last saw h.. alive on Feb 6 1945
Immediate cause of death Cerebral Thrombosis — DURATION 2 days
Due to General arteriosclerosis. 10 yrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L W Malin M.D. M. D. or other
Address Riverdale Md. Date signed 2-7-45

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

01959

Reg. Dist. No. 231

FILM No. G 94 APR 13 1945

1. PLACE OF DEATH:
County: PRO. GEORGE'S CO
City or town: COLMAR MANOR - MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRO GEO. CO
City or town: COLMAR MANOR MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3407 - 37TH PLACE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: NELLIE G. BRAMHALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: CHARLES BRAMHALL
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): JULY 21, 1880.

8. AGE: Years	Months	Days	If less than one day
~~73~~ 64			____ hrs. ____ min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: OWN HOME.

FATHER
12. Name: WM A. SORRELL
13. Birthplace: VA

MOTHER
14. Maiden name: MARIA JANE DOLEMAN
15. Birthplace: VA

16. Informant: LAWRENCE SORRELL
Address: COLMAR MANOR MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB 8, 1945 (month) (day) (year)
Cemetery or crematory: FORT LINCOLN
Location: COLMAR MANOR MD

18. Funeral director: F. GASCH'S SONS
Address: HYATTSVILLE MD.

19. Feb. 7 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB 5, 1945, at 3.22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1934 to Feb. 5 1945
and that I last saw h... alive on Feb. 3 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions: T.B. Cervical Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Hyattsville Md Date signed 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

01951

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riggs Mill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: On Potomac Electric Power Co. Right of Way

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 807 Mt. Vernon St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Nancey Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years: 38 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Store

FATHER 12. Name: David H. Brown

13. Birthplace: Virginia

MOTHER 14. Maiden name: Annie Brookes

15. Birthplace: Virginia

16. Informant: Arthur T. Brown

Address: 2308 Tulane Rd NW Wash DC

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Feb 7. 1945 (month) (day) (year)

Cemetery or crematory: Waynesboro Va

Location: Waynesboro Va

18. Funeral director: F Gaschio Sons

Address: Hyattsville Md.

19. Feby 7 1945 (Date rec'd by registrar) Mrs. Jas. Lowe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute dilatation of heart	
Due to: Exposure to Cold	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of: 2-4-45

Where did injury occur? Riggs Mill (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Mr. Woods

Means of injury: Lay out in Cold Injured at Work? No

23. SIGNATURE: James J. Bond M.D. or other

Deputy Medical Examiner

Address: Hyattsville Md. Date signed: 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

01952

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Leland Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): Headon Arrival

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4911 - Fox

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Amos Bryant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife: Rose P. Bryant

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1893

8. AGE: Years: 51 | Months: 10 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Berwyn, Md (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: U. S. Govt.

FATHER — 12. Name: George W. Bryant

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ellen E. Grimes

MOTHER — 15. Birthplace: Maryland

18. Informant: Rose P. Bryant

Address: Berwyn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-22-45 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cimetry

Location: Wash - D. C

18. Funeral director: W. W. Chambers Co

Address: Riverdale, Md.

19. Feby 21st 1945 (Date rec'd by registrar) John D. Snaith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 20 1945, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations:

Ot autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James D. Boyd M. D. or other

Address: Forestville Md Date signed: 2-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01953

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4702 Oliver St. Riverdale Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard Henry Campbell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 6 1871

8. AGE: Years: 73 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Painting

FATHER
12. Name: Richard Henry Campbell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Elizabeth Goods
15. Birthplace: Virginia

18. Informant: Brother - Walton D. Campbell
Address: 4706 Oliver St. Riverdale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 14, 1945. (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Alexandria Va

18. Funeral director: F. Gaskie sons.
Address: Hyattsville Md.

19. Feb 14 1945 (Date rec'd by registrar) James Sevens By R. S. S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945, at 12 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11 1945 to Feb 12 1945
and that I last saw h. alive on Feb 12 1945

	DURATION
Immediate cause of death: Broncho-Pneumonia	3 days
Due to:	
Due to:	
Other conditions: Arterio-sclerosis generalized (Include pregnancy within 3 months of death)	7 yrs.

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. C. Malin, M.D. M. D. or other
Address: Riverdale, Md. Date signed: 2-14-45

STATE OF MARYLAND—CERTIFICATE OF DEATH

01954 2 40

1. PLACE OF DEATH

County Pr. George — Registration Dist. No. 2 40

Village or City Baden, md — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME James Higgins Carr — If U. S. Veteran, specify WAR ____

(a) Residence: No. Baden, md. St., ____ Ward. ____
(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eliza Sullivan Carr

6. DATE OF BIRTH (month, day, and year) March 3, 1865

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
79	11		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date deceased last worked at this occupation (month and year) ____ — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Annapolis (State or country) Anarundel, md

FATHER

13. NAME Philip Dorsey Carr

14. BIRTHPLACE (city or town) ____ (State or country) md

MOTHER

15. MAIDEN NAME Sally Higgins

16. BIRTHPLACE (city or town) ____ (State or country) md

17. INFORMANT Stuart K. J. Carr (Address) Baden, md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place Croom, md Date Feb. 6 1945

19. UNDERTAKER Huntt & Ryon (Address) Waldorf, md.

20. FILED Feb 6, 1945 F H Billingsley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb 4 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1943, 19__, to Feb 4, 1945

I last saw him alive on Feb 4, 1945; death is said to have occurred on the date stated above, at ____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: — Date of onset

Bi-lateral Pleural Effusion — Jan 9
Pleurisy — Jan 9

Other Contributory Causes of Importance:

Arterio Sclerotic Heart Disease
Auricular Fibrillation

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19__

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) Hagner Ryon M. D.

(Address) Hughesville

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1928*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

01955

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George's Co.

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5707 Landover Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carrick, Mrs Agnes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1869

8. AGE: Years	Months	Days	If less than one day
76	11	5	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Smith, Mr. Thomas

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Lewis, Elizabeth

MOTHER 15. Birthplace Md.

16. Informant Mrs. J. W. Swain

Address Rockville Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1945 (month) (day) (year)

Cemetery or crematory Wash. D.C.

Location

18. Funeral director W. W. Chambers

Address Washington, D.C.

19. Feb. 6 1945 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945, at 11 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1945, to Feb. 5 1945

and that I last saw her alive on Feb. 5 1945

Immediate cause of death	DURATION
Pulmonary Congestion and Edema with Pleural Effusion	12 hrs.
Due to Myocandial Degeneration and Dilatation.	1 year
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles C. Hageage M.D.

M. D. or other

Address Mt. Rainier, Md. Date signed Feb. 6, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01956

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days.
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Bristol - Rural -
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Evelyn Rebecca Catterton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife Single
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 - 1907

8. AGE: Years	Months	Days	If less than one day
37	10	27	hrs. min.

9. Birthplace Friendship - Anne Arundel (Town, County, and state)
10. Usual occupation Housework
11. Industry or business Same
FATHER 12. Name Ernest A. Catterton
13. Birthplace Calvert County
MOTHER 14. Maiden name Annie Stallings
15. Birthplace Calvert County
16. Informant Ernest Preston Catterton
Address Bristol, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Mt Zion Md.
18. Funeral director T. B. Hardesty & Son
Address Galesville Md.
19. Feb. 8 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at 5:55 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1945 to Feb 8 1945 and that I last saw her alive on Feb 8 1945

Immediate cause of death	DURATION
Miliary Tuberculosis	6 months
Due to	
Due to	
Other conditions Pellagra	4 months

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. —
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None Injured at work? —

23. SIGNATURE James E. Tasker M.D. M. D. or other
Address Upper Marlboro, Md Date signed 2-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-P

CERTIFICATE OF DEATH

01957 234
Reg. Diat. No.

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forestville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Malcolm Clements
3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Lillie Clements
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): Oct 27 - 1884

8. AGE: Years	Months	Days	If less than one day
60	3	11	hrs. min.

9. Birthplace: Prince Georges Co. Md-Wald
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Farming
FATHER 12. Name: John Clements
13. Birthplace: Charles Co. Md
MOTHER 14. Maiden name: Alice Spencer
15. Birthplace: Prince Geo. Co. Md
16. Informant: Lillie Clements
Address: Waldorf Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 9 1945 (month) (day) (year)
Cemetery or crematory: Christ Church Cemetery
Location: Clinton Md
18. Funeral director: Thomas F. Murray
Address: 2067 - Nichols Ave SE
19. 2/7 1945 Mrs Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7 1945, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 7 1945
and that I last saw him alive on Febr 4 1945

Immediate cause of death: Osteo-Sarcoma of Knee & Thigh — DURATION: 6 mo
Due to: Injury to Knee
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Dr Shearer - Wash D C Garraguts Dlg — Date of op. Oct - 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E. Powers Md
M. D. or other
Address: Brandywine Md Date signed: 2/9/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01958

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: PRINCE GEORGE
City or town: HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 YEAR AND 1 MONTHE
Hospital, institution, or street address where death occurred:
SACRED HEART HOME
How long in hospital or institution? 1YR & 1MO.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3725 VEASEY ST. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: ELLEN J. CONNELLY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH 25, 1868

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: WASHINGTON D.C. (Town, county, and state)
10. Usual occupation: NONE
11. Industry or business:
FATHER 12. Name: JOHN CONNELLY
13. Birthplace: IRELAND
MOTHER 14. Maiden name: ANNA McGUIRE
15. Birthplace: IRELAND
16. Informant: SACRED HEART HOME RECORDS
Address: HYATTSVILLE, MD.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 3-3-45 (month) (day) (year)
Cemetery or crematory: MT OLIVET CEMETERY
Location: WASHINGTON D.C.
18. Funeral director: Francis J. Collins
Address: 3821 14th. St. NW.
19. March 1, 1945 (Date rec'd by registrar) James Deane By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28, 1945 at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 28 1945 and that I last saw her alive on Feb 27 1945

Immediate cause of death	DURATION
arteriosclerotic Heart Disease	1 YR.
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas F. Collins M. D. or other
Address: 322 - H St. NE Date signed: Feb 28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 9,4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

01959

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince George
City or town: Muirkirk (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Muirkirk (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph H. Conway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14 1860

8. AGE: Years 84 | Months 9 mos | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name unknown
FATHER 13. Birthplace unknown

MOTHER 14. Maiden name unknown
MOTHER 15. Birthplace unknown

16. Informant Ellen Reese
Address Muirkirk Md.

17. Queens Chapel (Burial, cremation, or removal? Which?) Date thereof Feb. 14 45 (month) (day) (year)
Cemetery or crematory Queens Chapel
Location Muirkirk Md.

18. Funeral director J. B Johnson
Address Annapolis Md.

19. Feby 13 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION 3/11/45

20. DATE OF DEATH February Exact 1945 at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944 to 2/11 1945
and that I last saw him alive on 2/10 1945

Immediate cause of death	DURATION
Cancer Bladder	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

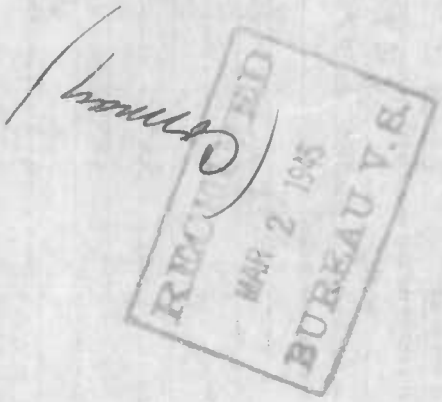
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or Other
Address [illegible] Date signed 3/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01965 P

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5103 43rd Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rose Eveline Coveney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Dennis J Coveney

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Apr 16 1858

8. AGE: Years	Months	Days	If less than one day
86	10	4	..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: James H Reaume

13. Birthplace: Md

MOTHER — 14. Maiden name: Eveline Reaume

15. Birthplace: Md

16. Informant: Miss Rose M Coveney

Address: 5103 43rd Ave

17. (Burial, cremation, or removal, Which?) Burial Date thereof 2-24-45 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore Md

18. Funeral director: George A Fuller

Address: Catonsville

19. 2/23 1945 H. W. Kedrick per S.M. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-22 1945 at 10:20 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-31 1944, to 2-22 1945 and that I last saw h.... alive on 2-22 1945

	DURATION
Immediate cause of death: Terminal Bronchial Pneumonia	4 days
Due to: Hypertensive Cardio Vascular Disease	4 years
Due to:	
Other conditions: Cerebral Hemorrhage Left Hemiplegia	15 months

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W Berryman M.D. (M. D. or other)

Address: Mt. Rainier Md Date signed 2-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-E)

CERTIFICATE OF DEATH

01961

Reg. Diat. No. 246

1. PLACE OF DEATH:

County Prince Georges.

City or town Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above piece ot death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges.

City or town Riverdale.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6408 - 61 ot. Street.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virginia Fitzhugs Crawley

3.(b) Social Security Number 7110 -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Single.

6.(b) Name ot husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1886.

8. AGE: Years	Months	Days	If less than one day
58	2	12	hrs. min.

9. Birthplace Charleston, South Carolina.
(Town, county, and state)

10. Usual occupation clerk.

11. Industry or business War Production Board

FATHER 12. Name George Fitzhugs Crawley

13. Birthplace Norfork - Virginia.

MOTHER 14. Maiden name Louisa Ludelaide Davant

15. Birthplace South Carolina.

16. Informant patients a hart.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)

Cemetery or crematory Nat. Meml. Park

Location Riggs Rd. near

18. Funeral director Wm Chaseubro, C.

Address Riverdale md.

19. Feb 16 1945 (Date rec'd by registrar) Mary E Kiser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 6 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1945, to Feb 16 1945

and that I last saw h[illegible] alive on Feb 16 1945

Immediate cause of death	DURATION
Primary Cyrcinoma of Bronchus with	6 mo.
Due to: General Metastases	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Sans

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Malin MD M. D. or other

Address Riverdale Md Date signed 2-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01962

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George 's

City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 7 mos., 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2116-A 38th St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Sol M. Davidson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1897

8. AGE: Years	Months	Days	If less than one day
47	10	4	hrs. min.

9. Birthplace: Transvaal, South Africa
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: —

MOTHER FATHER

12. Name: Morris Davidson

13. Birthplace: Germany

MOTHER

14. Maiden name: Lena Rovell

15. Birthplace: Germany

16. Informant: Decedent

Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) Feb. (day) 15, (year) 1945

Cemetery or crematory: Washington Jewish Cem. D.C.

Location: Richmond, Va.

18. Funeral director: Henry V. Walsh Inc.

Address: 29-7th St. N.W. Washington D.C.

19. Feb 14, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar
Replaced

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1945, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1943 to Feb. 14, 1945 and that I last saw h.. alive on Feb. 14, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	7 yrs. 1 mos.
Due to: Tuberculous enteritis	2 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

01963

1. PLACE OF DEATH

County Prince George's Registration Dist. No. 242

Village or City Fairmont Hghts, Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Rosana Dominess If U. S. Veteran, specify WAR

(a) Residence: No. 908 Addison Chapel Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Colored	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Dec 18 80

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Domestic

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. at home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Maryland
(State or country)

FATHER

13. NAME Aaron Dixon

14. BIRTHPLACE (city or town) Maryland
(State or country)

MOTHER

15. MAIDEN NAME Jane Bundy

16. BIRTHPLACE (city or town) Maryland.
(State or country)

17. INFORMANT Mary Adella Ashton
(Address) 908 Addison Chapel Rd.

18. BURIAL, CREMATION, OR REMOVAL
Place Date , 19

19. UNDERTAKER Arthur L. Rollins
(Address) 4339-1Hunt Place, NE.

20. FILED Feb. 5 1946 Irene A. Cooper
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
January (Month) 5 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1945, to Feb 5, 1946

I last saw h[illegible] alive on Feb 5, 1946; death is said to have occurred on the date stated above, at 9:00 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Hypertension	
Cardiovascular	?
Disease.	

Other Contributory Causes of importance:

Bronchial Asthma	?
Senility	

Name of operation Date of

Whet test confirmed diagnosis? Wes there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Nature of Injury

24. Wes disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. D.

(Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7(a)

01964

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince George's
City or town Brandywine, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Edelen

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife: Georgie H. Edelen
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 10, 1891

8. AGE: Years 53 | Months 7 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace: Surratts, Pr. Geo's, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: Rhinelda Edelen

13. Birthplace: Prince George's (in doubt)

MOTHER 14. Maiden name: Eliza Richards

15. Birthplace: Don't Know

16. Informant: Mrs. James H. Duley
Address: 6308 Livingston Rd. Wash. (20) D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 21, 1945 (month) (day) (year)
Cemetery or crematory: Finn's Episcopal
Location: Upper Marlboro, Md.

18. Funeral director: Pickie Burhans
Address: Upper Marlboro, Md.

19. Feb 20 1945 (Date rec'd by registrar) J. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1945 at 11:15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 1945 to Feb 18 1945
and that I last saw him alive on Feb 15 1945

Immediate cause of death	DURATION
Angina Pectaris	
acute Coronary Disease	3 days
Due to: unknown	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Van Natta M. D. or other
Address Washington 19 D.C. Date signed Feb 19 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

01965

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Forest Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Forest Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Madison Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME PATRICIA MAE ELLIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1944

8. AGE: Years | Months 4 | Days | If less than one day hrs min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name Frank Ellis
13. Birthplace Wilmington N.C.

MOTHER
14. Maiden name Maria Fedlon
15. Birthplace Washington D.C.

16. Informant Maria Ellis
Address 107 Madison Ave. Forest Hts

17. Burial Date thereof 3/2/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington
Location Arlington Va

18. Funeral director S.H. Chamberlain
Address 517-11th St. S.E.

19. 2-28-45 Irene A. Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 19 45 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/45 19 to 2/28/45 19
and that I last saw h.e.r alive on 2-26 19 45

Immediate cause of death	DURATION
Whooping cough	
Due to	
Due to	
Other conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 2015 Nichols P. Date signed 2/28/45

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01966

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Kenilworth
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Kenilworth
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4620 - R. St NE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JOSEPHINE ALICE EVANS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Fred Evans

7. Birth date of deceased (mo., day, yr.): Aug 11 1893 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51				

9. Birthplace: Penn (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Kinley
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ellen ?
15. Birthplace: Unknown

16. Informant: Fred Evans
Address: 4620 - R. St N.E.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-14-45 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E.

19. Feb. 14 1945 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14, 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1944 to Feb. 14 1945 and that I last saw her alive on February 13, 1945

Immediate cause of death	DURATION
Acute Left Ventricular Failure	16 days
Due to: Cardiovascular Renal Disease	16 days
Due to: Auricular Fibrillation	16 days
Due to:	
Other conditions: Carcinoma of the Cervix with Metastasis	9 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Isaac M. Cahn M. D. or other
Address: Mt. Rainier, Maryland Date signed: 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

01967

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Mt. Rainier, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4117-31st. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FRANK J. FAUTH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Theresa Fauth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 13, 1881

8. AGE: Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business

FATHER
12. Name: Julius R. Fauth
13. Birthplace: Virginia

MOTHER
14. Maiden name: Florence Crupper
15. Birthplace: Washington, D.C.

16. Informant: Mrs. Florence Rainey
Address: 4117-31st. St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2, 1945 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Washington, D.C.

18. Funeral director: William J. Malley.
Address: 3200-Rhode Island Ave. Mt. Rainier.

19. March 2, 1945 (Date rec'd by registrar) James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28, 1945, at 1 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1944, to Feb. 28, 1945
and that I last saw him alive on Feb. 27, 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles C. Hageage M. D. M.D. or other
Address: Mt. Rainier, Md. Date signed: Feb. 28 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

CERTIFICATE OF DEATH

01968 Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Mt. Rainier Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3104 - Shepherd St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME GRACIE HAZEL FREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Ralph Wylie Frey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1890

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace Centerville, Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Claucus Joseph Mahler
13. Birthplace Virginia

MOTHER
14. Maiden name Robinson
15. Birthplace Virginia

16. Informant Louis Frey Son
Address 3104 - Shepherd St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-45 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Washington, D.C.
18. Funeral director William J. Nalley
Address 3200 - R.I. Ave. Mt. Rainier, Md

19. Feb 17 1945 (Date rec'd by registrar) James Devere By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1945, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1944, to Feb. 14 1945 and that I last saw h[illegible] alive on Feb. 12, 1945

Immediate cause of death	DURATION
Carcinoma, buccal with metastases	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank R. Shea M.D.
M. D. or other
Address 4100 - V St. N.E. Wash. D.C. Date signed 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01969

CERTIFICATE OF DEATH

Reg. Diat. No. 234

1. PLACE OF DEATH:
County: Prince George
City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1929
Hospital, institution, or street address where death occurred: 4603 Branch Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4603 Branch Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: James Harry Garner Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) [redacted], widowed, [redacted]
male	white	Widowed

6.(b) Name of husband or wife: Jennie Emaline Garner
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 23rd 1884.

8. AGE: Years: 61 | Months: 0 | Days: 12 | If less than one day: ____ hrs. ____ min.

9. Birthplace: North Keys Md. (P.G.) (Town, county, and state)
10. Usual occupation: Clergyman.
11. Industry or business: Church work.
12. FATHER — Name: Thomas A. Garner.
13. FATHER — Birthplace: U.S.A. (Md)
14. MOTHER — Maiden name: Henrietta Garner.
15. MOTHER — Birthplace: U.S.A.
16. Informant: Son.
Address: 4601. Branch Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb-6-1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Md.
18. Funeral director: Thomas F. Murray
Address: 2007 Nicholson St
19. Feb. 4 1945 Received by Registrar: Edward J. Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4th 1945, at 11-10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5th 1944 to Feb 4th 1945
and that I last saw h[redacted] alive on Jan 24th 1945

Immediate cause of death	DURATION
Auricular Fibrillation. Coronary Thrombosis	
Due to: Ch. myocarditis.	
Due to: Coronary Thrombosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Louis M Ebb M.D. (M. D. or other)
Address: Suitland Md. Date signed: 2-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

(1970) Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4515 Emerson st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Appolonia Garrity

3. (b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Wm J. Garrity

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 4, 1860

8. AGE: Years: 84 | Months | Days | If less than one day: ..... hrs. ..... min.

8. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Peter Emrich
13. Birthplace: Germany

MOTHER
14. Maiden name: Maria Eli
15. Birthplace: Germany

16. Informant: James P. Garrity
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 3, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md

18. Funeral director: F. Gasch's sons
Address: Hyattsville Md.

19. March 1 1945 (Date rec'd by registrar) James Devere By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1942 to Feb 28 1945 and that I last saw h[illegible] alive on Feb 28 1945

	DURATION
Immediate cause of death: Mitral failure	
Due to: General arterio-sclerosis	
Due to:	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.:

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo W. Waterman M.D. M. D. or other
Address: Hyattsville Date signed: Mar 1 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

Evidence for addition of color of deceased is shown on FILM No. G 97 AUG 2 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

CERTIFICATE OF DEATH

01971

Reg. Diat. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Geo. Co
City or town: Silesia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Silesia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Virginia Goens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec. 25th 1861

8. AGE:

Years	Months	Days	If less than one day
83	1	11	— hrs. — min.

9. Birthplace: Alexandria Va (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: —

FATHER
12. Name: Not known
13. Birthplace: —

MOTHER
14. Maiden name: Not known
15. Birthplace: —

16. Informant: Richard B. Edelen
Address: Silesia Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Feb 13-45 (month) (day) (year)
Cemetery or crematory: St. Johns Episcopal
Location: Broad Creek Md.

18. Funeral director: Thomas F. Murray
Address: 2007 Nichols Ave S.E.

19. Feb 11 1945 (Date rec'd by registrar) Howard I Bissell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-11 1945, at 1 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-9 1945, to 2-9 1945 and that I last saw h[er] alive on 2-9-45 1945

Immediate cause of death: Cardiac Decompensation — DURATION: Unknown

Due to: Arteriosclerosis & senile nutrition

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Arthur N. Meloy M. D. or other
Address: 4400 Bowen Rd. D.C. Date signed 2-11-45

Evidence for change of age of deceased is shown on FILM No. G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01972 P

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince George

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3537 Newland Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MALCOLM J. GOUDELOCK

3.(b) Social Security Number: 218-22-7531

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lurana Hopkins

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 31, 1883

8. AGE: Years	Months	Days	If less than one day
62 61	1	13	..... hrs. ..... min.

9. Birthplace: Gaffney, S. C.

(Town, county, and state)

10. Usual occupation: Relief Druggist

11. Industry or business: McComas Druggist, Roxton Pharmacy Maryland Drug Co.

FATHER

12. Name: John H. Goudelock

13. Birthplace: Gaffney, S. C.

MOTHER

14. Maiden name: -- Jefferies

15. Birthplace: Gaffney, S. C.

16. Informant: Mr. Francis S. Carnes

Address: 901 Hatherleigh Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 2/16/45 (Date rec'd by registrar) C. W. Hedrick per M.N Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb -14 1945 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 14 1945 to Feb 14 1945

and that I last saw him alive on 2-14 1945

Immediate cause of death	DURATION
Angina Pectoris	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. B. Jarrard M. D. or other

Address: 332 E. Fayette Baltimore Date signed: 7/13/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.
11/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01973

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 11 mos.

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 years, 11 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 807 - 10th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: WILLIAM A. GREGORY

3. (b) Social Security Number: 144-10-7567

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married (separated)

6.(b) Name of husband or wife: Bessie Gregory

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): February 27, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	20	...hrs. ...min.

9. Birthplace: Newark, New Jersey (Town, county, and state)

10. Usual occupation: Iron Worker

11. Industry or business: —

FATHER — 12. Name: Patrick Gregory; 13. Birthplace: New Jersey

MOTHER — 14. Maiden name: Mary Boyle; 15. Birthplace: New Jersey

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Feb. 16, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Huntemann Funeral Home

Address: 5732 Georgia ave, N.W.

19. Feb. 16, 1945 (Date rec'd by registrar) Rowland S. Phillips (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 16th 1945 at 3 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 5th 1943, to Feby 16th 1945 and that I last saw him alive on Feby 16th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to: Complications: —	
Due to: Acute Nephritis	1 mo.
Pericarditis	19 da.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Bilateral fibro caseous pulmonary tuberculosis, multilateral small cavities, sero fibrinous pericarditis, bilateral pleural effusion and ascites, acute glomerulo-nephritis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide? Date of injury: Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Pincare M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 2/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01974 Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr Georges
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4809 - 52nd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frank Lincoln Harris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

8.(b) Name of husband or wife Josephine Harris
8.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 25 1860

8. AGE: Years	Months	Days	If less than one day
79 yrs	2 mos	19 days	____ hrs. ____ min.

8. Birthplace New York
(Town, county, and state)
10. Usual occupation Oil Dealer
11. Industry or business City Service Oil Co

FATHER
12. Name Charles Harris
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

18. Informant Pt's Chart
Address

17. Burial Date thereof Feb 17, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Colmar Manor Md

18. Funeral director F Gascho Sons
Address Hyattsville md

19. Feb 15 1945 Mrs Lee Beverly Registrar
(Date rec'd by registrar) Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945 at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to Feb 13 1945
and that I last saw h. alive on Feb 13 1945

Immediate cause of death	DURATION
Carcinoma of prostate	
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE W E Malin MD M. D. or other
Address Hyattsville md Date signed July 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01975 Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Maryland Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred: 101-64 Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Maryland Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 101-64 Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Jesse Hayes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Marcia Hayes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1858

8. AGE: Years	Months	Days	If less than one day
87	0	30	..... hrs. ..... min.

9. Birthplace: Carlisle Pa. (Town, county, and state)

10. Usual occupation: Retired Street Commissioner

11. Industry or business

FATHER 12. Name: Solam Hayes

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Catherine Jones

15. Birthplace: Pennsylvania

16. Informant: Carrie M. Bosley

Address: 101-64 Street Md. Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 8 (month) (day) 1945 (year)

Cemetery or crematory: Westminster Cemetery

Location: Carlisle Pa.

18. Funeral director: J. C. Hutt & Son Roy E. Hoffman

Address: Carlisle Pa.

19. Feb. 6 — 1945 — Irene A. Comer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 19 45, at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James D. Long M. D. or other

Address: Forestville Md. Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01976

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George Co
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 min
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: College City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3702 - 41st Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Diane Henry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 months Sept. 14-1943

8. AGE: Years: 1 | Months: 5 | Days: | If less than one day: hrs. min.

9. Birthplace: Monrovia Calif. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business:

FATHER
12. Name: Robert Henry
13. Birthplace: Rutledge Tenn

MOTHER
14. Maiden name: Mary C Bruns
15. Birthplace: Philadelphia Penn.

16. Informant: (Father) Robt. Henry
Address: 3702 - 41st St. College City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-13-45 (month) (day) (year)
Cemetery or crematory: Nat. Memorial Cemetery
Location: Ft. Meyer, Va.

18. Funeral director: W. W. Chandler & Co
Address: Riverdale Md.

19. Feb. 12 1945 (Date rec'd by registrar) Amanda Dawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 1945 at 4:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Intracranial hemorrhage	
due to Shock	
due to Compound fracture of skull	
due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of injury: 2-10-45
Where did injury occur? College City (City or town) Prince Georges (County) Md. (State)
Injured at home, farm, industry, public place (where?): Driveway & house
Means of injury: Running Car Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: M. D. or other
Address: Hyattsville Md. Date signed: 2-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01977

Reg. Dist. No. 425

1. PLACE OF DEATH:

County: Prince Georges

City or town: Landover Hills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: Sheriff Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: P. Geo.

City or town: Landover

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sheriff Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Henson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Annie Henson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 65 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mitchellville, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Buck Mfg. Co.

FATHER — 12. Name: Joseph Henson

FATHER — 13. Birthplace: Ann Arundel Co. Md.

MOTHER — 14. Maiden name: Ellen Henson

MOTHER — 15. Birthplace: Ann Arundel Co. Md.

16. Informant: Clarence Henson

Address: 6438-H St. Cedar Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-20-1945 (month) (day) (year)

Cemetery or crematory: Holy Family

Location: Mt. Lebanon, Md.

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. Feb. 19 — 1945 (Date rec'd by registrar) Verna A. Bowne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 16 1945, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Feb 16 1945 and that I last saw him alive on Feb 14 1945

Immediate cause of death	DURATION
Cardio Pneumonia	.....
Due to: Disease,	?
Due to: Hypertension	?
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Belden M.D. M. D. or other

Address: 3 — Mount Pl. Hyattsville Md. Date signed: 2-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01978

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 weeks
Hospital, institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Mary's Co
City or town: Compton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. 2 Box 60
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: William Hiller

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Alice M. Hiller
6.(c) If alive, give age ____ years

7. Birth date of deceaaed (mo., day, yr.): Oct. 1, 1867

8. AGE: Years	Months	Days	If less than one day
78			____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Truck Gardenerr
11. Industry or business

FATHER
12. Name: Henry Hiller
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Louise Eppard
Address: 4101 Minna. Ave Washington D. C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16, 1945 (month) (day) (year)
Cemetery or crematory: Addison Chapel
Location: Seat Pleasant Maryland

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland.

19. Feb 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-13-45 19____, at 11:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-9-45 19____, to 2-13-45 19____ and that I last saw h. 1m alive on 2-12-45 19____

Immediate cause of death	DURATION
Myocardial failure	5 hrs.
Due to Cardio-vascular renal Disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: John P. Clem M.D. M. D. or other
Address: Hyattsville Md Date signed 2-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01979

Reg. Diat. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

Strawberry Hill Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. Strawberry Hill Farm

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thorton Leon Holmes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Mary Holmes

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 14, 1895

8. AGE: Years	Months	Days	If less than one day
49	9	8	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Tonia Holmes

13. Birthplace Maryland

MOTHER 14. Maiden name Florence Spriggs

15. Birthplace Maryland

16. Informant Mary Holmes

Address Upper Marlboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 45 (month) (day) (year)

Cemetery or crematory Lincoln Memorial

Location Suitland, Md

18. Funeral director J.B. Johnson

Address Annapolis

19. Feb 27 1945 (Date rec'd by registrar) R. Caulfield Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Tuberculosis	
Due to Pneumonia, Broncho	
Duration 1 one week	
Other conditions Cirrhosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner

M. D. or other

Address Forestville Md Date signed 2-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

01980

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State ~~Maryland~~ District of Columbia County —

City or town Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 5414 - 2nd St. N.W. Washington DC (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs. Catherine Bertha Hough

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Ira Hough

deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

FATHER 12. Name George - Dixie

13. Birthplace ?

MOTHER 14. Maiden name Dexter - Emerson

15. Birthplace Washington DC

16. Informant daughter - Mrs. Helen S. Barry

Address 5414 - 2nd St, N.W, Wash, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb 25 1945 (month) (day) (year)

Cemetery or crematory .....

Location Washington D C

18. Funeral director J W M Lee Sons

Address 300 - 4th St N E

19. Feb. 25 1945 (Date rec'd by registrar) Mrs Jay Deese Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 45 at 3 32/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 19 44 to Feb 25 19 45

and that I last saw her alive on Feb 24 19 45

Immediate cause of death	DURATION
Diabetic Gangrene of feet and back.	4 yrs
Due to Diabetes Mellitus	6 yrs.
Due to	
Other conditions General Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. W. Malin MD (M. D. or other)

Address Riverdale Date signed 2-25-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01981

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Brentwood Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hrs.
Hospital, institution, or street address where death occurred:
Brentwood Sanatorium.
How long in hospital or institution? 8 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Fairfax
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ft Belvoir
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: Harry Vivian Ishum

3. (b) Social Security Number: 228-26-9351.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bertha (deceased)
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): JAN 1891.

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace: Kansas City, Mo.
(Town, county, and state)
10. Usual occupation: Fire Chief.
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant:
Address:

17. Removed
(Burial, cremation, or removal. Which?) Date thereof: 2/24/45 (month) (day) (year)

Cemetery or crematory:
Location: Occoquan, Va.,
18. Funeral director: J. Veach's Sons
Address: Hyattsville, Md.

19. Feb. 24 1945 James Sweeney
(Date rec'd by registrar) By R.S.S., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24 1945 at 6:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23 1945 to 2/24 1945 and that I last saw him alive on Feb. 23-24 1945

Immediate cause of death	Congestive heart failure	DURATION
Due to	Lobar pneumonia, bilateral	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert D. Stewart, Jr. M.D.
M. D. or other
Address: The Brentwood Sanatorium Date signed: 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01982

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos., 5 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1242- 12th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: GEORGE ALEXANDER JACOBS

3. (b) Social Security Number: 063-01-0645

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, 1909

8. AGE: Years	Months	Days	If less than one day
35	4	8	hrs. min.

9. Birthplace: Burlington, Vermont (Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business

FATHER
12. Name: Leon Jacobs
13. Birthplace: Richford, Vermont

MOTHER
14. Maiden name: Mary Wilson
15. Birthplace: Richford, Vermont

16. Informant: Decedent
Address

17. Feb. 13, 1945 (Burial, cremation, or removal. Which?) Removal to Date thereof (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: WW Chambers Co
Address: 1400 Chapin St N.W.

19. Feb. 12, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar
Dewood

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 7 1944, to Feb. 12, 1945
and that I last saw him alive on Feb. 12 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3yrs 2 mo
Antecedent:	
Complication: Right tuberculous	
Due to: Empyema	7½ mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Bilateral fibrocaseous pulmonary
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: tuberculosis, ulcerated caulation, st. the. empyema, tuberculous peritonitis + enteritis
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 2/12/45

M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-C)

CERTIFICATE OF DEATH

01983

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Riverdale.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4530 Woodberry Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War - 1.

3.(a) FULL NAME: Mr. John Jurney

3.(b) Social Security Number: 579-03-7568

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Cleo. Jurney.

7. Birth date of deceased (mo., day, yr.): July 8, 1895 — 8.(c) If alive, give age: 49 years

8. AGE:

Years	Months	Days	If less than one day
49	6	28	....hrs. ....min.

9. Birthplace: Asheville, N. C. (Town, county, and state)
10. Usual occupation: mechanic.
11. Industry or business: mechanic
FATHER — 12. Name: Columbus C. Jurney
13. Birthplace: North Carolina
MOTHER — 14. Maiden name: Ellen Walland
15. Birthplace: north Carolina.
16. Informant: Mrs. Cleo. Jurney.
Address: Riverdale Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-10-1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: William J. Malley
Address: 3200-Rhode Island Ave. Mt. Rainier, Md.
19. Feb 9 1945 (Date rec'd by registrar) Mrs. Jos. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 1945, at 3 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1945, to February 7, 1945 and that I last saw h. l.m. alive on February 7, 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 days
Due to: Cardiovascular Renal Disease	7 months.
Due to:	
Other conditions: Hypertension 220/140 to 260/130	7 months
Right Hemiplegia (Include pregnancy within 6 months of death)	3 days

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Isidor M. Levine M. D. or coroner
Address: Mt. Rainier, Md. Date signed: 2/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11934 230

1. PLACE OF DEATH:

County: Prince Georges

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Inv Agricultural Building

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Indiana County: Tippecanoe

City or town: West La Fayette

(If outside city or town limits, write RURAL and give nearest town)

Street No. 625 Russell Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: grace Randal King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 12, 1906

8. AGE:	Years	Months	Days	If less than one day
	38	2	17	hrs. min.

9. Birthplace: St Louis Mo (Town, county, and state)

10. Usual occupation: News writing

11. Industry or business: Univ of Maryland

FATHER — 12. Name: E. W. Randall

FATHER — 13. Birthplace: Charleston, Mo.

MOTHER — 14. Maiden name: Laura Clifford

MOTHER — 15. Birthplace: West Side Iowa

16. Informant: Mrs Howard Osborn

Address: 2510 Cooper St, Parkersburg

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: Feb 28, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Maryland

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md.

19. (Date rec'd by registrar) Friday 2 Mar 1945 John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Rheumatic heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James D. Bond M. D. or other

Address: Forestville Md Date signed 2-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-7)

CERTIFICATE OF DEATH

0195

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 21 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1028 - 3rd St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

✓

3. (a) FULL NAME

Edith E. Laney ~~Laney~~

3. (b) Social Security Number

?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Eugene Laney

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): June 25, 1924

8. AGE:	Years	Months	Days	If less than one day
	20	8	2	....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Mail Clerk

11. Industry or business: —

FATHER
12. Name: Iver Smith
13. Birthplace: Estel, South Carolina

MOTHER
14. Maiden name: Sadie Cunningham
15. Birthplace: Columbia, South Carolina

16. Informant: Eugene H. Laney - Husband
Address: 1028- 3rd St. N. E., D. C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 27-1945 (month) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: Thomas Funeral Co.
Address: 389 - 9. D. Ave. N. W. Wash.

19. Feb. 27 1945 (Date rec'd by registrar) Rowland L. Phelps Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1945 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1944 to Feb. 27 1945 and that I last saw h.e.r. alive on Feb. 27 1945

Immediate cause of death	DURATION
Tuberculosis	4 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.: ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed 2/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01986 Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 323 - 4th St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: WALTER LASSITER

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Carrie B. Lassiter
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1888

8. AGE: Years	Months	Days	If less than one day
56	4	11	....hrs. ....min.

9. Birthplace: Orlando, North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: –

FATHER
12. Name: William Lassiter
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Finer
15. Birthplace: North Carolina

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2/15/45 (month) (day) (year)
Cemetery or crematory: /
Location: Washington DC.
16. Funeral director: Mahan & Sons
Address: 424 - R St NW

19. Feb 14, 1945 (Date rec'd by registrar) Rowland S. Phillips Reg. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1945, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 7, 1945, to February 14 1945
and that I last saw h... alive on February 14 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	8 mo.
Complication: Right spontaneous pneumothorax	1 month
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

01087 Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County Prince Geo
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Geo
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Adelbert Lawson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Lillie E
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec 23 - 1885

8. AGE: Years 59 | Months 1 | Days 30 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Guard (retired)
11. Industry or business Md House of Correction

FATHER
12. Name Henry C Lawson
13. Birthplace Md

MOTHER
14. Maiden name Laura V. Grimes
15. Birthplace Md

16. Informant Harold Lawson
Address Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24-45 (month) (day) (year)
Cemetery or crematory Hyattstown
Location Hyattstown, Md
19. Funeral director Lloyd Lauer
Address Laurel Md

19. Feb. 24 19 45 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22. 45, at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 19 44, to Feb 22 19 45
and that I last saw h... alive on Feb. 21 19 45

Immediate cause of death	DURATION
Pulmonary Hemmorrhage	- 4 hr.
Due to Pulmonary Tuberculosis	1 +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Pickard M. D. or other
Address Laurel Md Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01988

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 C. St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Burnice Manning

3.(b) Social Security Number: 243-18-1243

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B.(b) Name of husband or wife: Evelyn Manning

B.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): April 8, 1914

8. AGE:

Years	Months	Days	If less than one day
30	10	6	...hrs. ...min.

9. Birthplace: Maxton, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: –

FATHER
12. Name: Dennis Manning
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Arry Jane Douglas
15. Birthplace: North Carolina

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

19. Funeral director: John T. Phillips & Co.

Address: 901 - 3rd. St. S.W.

19. Feb. 14, 1945 (Date rec'd by registrar) Rowland S. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14, 1945, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13, 1944, to Feb 14, 1945

and that I last saw him alive on Feb 14, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3 Yr mo

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 2.14.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01989

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 7 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2730 Wisconsin Ave., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM Mc DONALD

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine McDonald
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): October 8, 1883

8. AGE: Years	Months	Days	If less than one day
61	4	12	...hrs. ...min.

9. Birthplace: Houston, Texas (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: —

FATHER
12. Name: Duncan McDonald
13. Birthplace: Nova Scotia

MOTHER
14. Maiden name: ? Whyte
15. Birthplace: Scotland

16. Informant: Decedent
Address

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (mouth) (day) (year)
Cemetery or crematory
Location: Washington - D.C.
18. Funeral director: Joe F. Birch's Son
Address: 503 x 9th St N.W. Wash. D.C.

19. Feb 20 1945 Rowland S. Phillips Dep. Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1945 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1944, to Feb. 20 1945 and that I last saw h...m alive on Feb. 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 2/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

01990

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Geo. County
City or town: Cheverly Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred: Prince Geo. Gen. Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No.: 411 Washington Blvd (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Franklin Merson
3. (b) Social Security Number:

4. Sex: Male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mrs. Ruby Shipley Merson
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): Jan. 27, 1892

8. AGE: Years	Months	Days	If less than one day
53		27	....hrs. ....min.

9. Birthplace: Montgomery Co. Md. (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: Library of Congress
FATHER 12. Name: Thomas Wesley Merson
13. Birthplace: Montgomery Co., Md.
MOTHER 14. Maiden name: Sara
15. Birthplace: Montgomery Co. Md.
16. Informant: Mrs. Ruby Shipley Merson
Address: 411 Washington Blvd. Laurel Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26, 1945 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel Md
18. Funeral director: [illegible]
Address: Laurel, Md
19. Feb. 22 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 22 1945, at 6:9 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1945, to Feb 22 1945
and that I last saw him alive on Feb 21 1945

Immediate cause of death: Cerebral Haemorrhage — DURATION: ?
Due to:
Due to:
Other conditions: (Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Laurel Md Date signed: 2/22/45

June 26-1962

Pubs 782
Ed 2685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01991

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince Georges

City or town Ammendale Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Ammendale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Beltsville Post office

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Dosethius Micheal

3. (b) Social Security Number

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug 26 - 86

8. AGE: Years 58 Months 6 Days 19 If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business Religious

FATHER 12. Name Michael Farr

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Downs

15. Birthplace Ireland

16. Informant Brother Elias Director

Address Beltsville P. Office

17. Burial Date thereof Feb. 17 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Normal Institute

Location Ammendale

18. Funeral director W. W. Chambers Co

Address Riverdale Md.

19. Feb 16 1945 John D. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 14 1945, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1943, to Feb 14 1945

and that I last saw him alive on Feb 14 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 Day
Due to Hypertensive Cardio-Vascular Renal Disease	10 Yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE J M Warren MD

M. D. or other

Address Laurel, Md. Date signed 2/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

01992

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Oak Crest Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George

City or town Oak Crest Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME [redacted] Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. min.

9. Birthplace Oak Crest P.G.Co Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Mose Moore

13. Birthplace Md

MOTHER

14. Maiden name Mabel Powell

15. Birthplace Md

16. Informant Mose Moore

Address Oak Crest R.F.D Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16 1945 (month) (day) (year)

Cemetery or crematory Bacons

Location Anne Arundel Co Near Laurel Md

18. Funeral director Ridgly Selby

Address 40 1 Wash ave Laurel Md

19. Feb. 16 1945 Cpl E. Wachter Deputy. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-16 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Feb 16 1945

and that I last saw him alive on Feb 16 - 1945

Immediate cause of death	DURATION
accidental Suffocation	Instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W B Sanford M. D. or other

Address Laurel Md Date signed 2/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

CERTIFICATE OF DEATH

01993

Reg. Diat. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County Prince George
City or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months & 26 days
Hospital, Institution, or street address where death occurred:
428 Main St.
How long in hospital or institution? 3 mos. & 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New Jersey County
City or town Camden
(If outside city or town limits, write RURAL and give nearest town)
Street No. Plaza Hotel 5th & Cooper Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Pierre Marion Moriarty

3. (b) Social Security Number 151-01-2672

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th, 1870

8. AGE: Years	Months	Days	If less than one day
74	7	0	hrs. min.

9. Birthplace Laurel Prince Geo. Md. (Town, county, and state)
10. Usual occupation Business Executive
11. Industry or business New York Shipbuilding Corp.
FATHER 12. Name C. M. Moriarty
13. Birthplace Unknown
MOTHER 14. Maiden name Georgina Milstead
15. Birthplace Laurel Md.
16. Informant Alfred Versfelde
Address 426 Main St. Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13 1945 (month) (day) (year)
Cemetery or crematory Dug Hill
Location Laurel Md.
18. Funeral director The W. C. White Co. Inc.
Address Main. Blvd. Laurel Md.
19. Feb. 13 1945 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 3:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1943, to Feb 10 1945 and that I last saw h.. alive on Feb 10 1945.

Immediate cause of death	DURATION
Carcinoma Liver	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. B. Raymond M. D. or Other
Address Laurel Date signed Feb 12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

61554

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or Institution? 3 hours 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town College Park.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7204 Bowdoin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary Agnes Murphy

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

8.(b) Name of husband or wife Jerry Henry Murphy deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 16, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	17	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home.

FATHER 12. Name John Randolph Walton.

13. Birthplace Maryland.

MOTHER 14. Maiden name Margaret Rebecca Marshall

15. Birthplace Maryland.

18. Informant pta Chatt.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 2, 1945 (month) (day) (year)

Cemetery or crematory Glenwood

Location Washington D.C.

18. Funeral director E. Gascha sons

Address Hyattsville Md

19. March 1 1945 (Date rec'd by registrar) James Levere By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1945, at 6 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941, to Feb 28 1945 and that I last saw h alive on Feb 28 1945

	DURATION
Immediate cause of death Lobar Pneumonia	4 days.
Due to Cerebral Thrombosis with Left Hemiplegia	5 days.
Due to General arterio sclerosis	20 years.
Other conditions Interstitial cystitis	10 years.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Atypical Lobar Pneumonia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.O. Mulin MD M. D. or other

Address Riverdale Md Date signed 3-28-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

01995

Reg. Dist. No. 232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, institution, or street address where death occurred: Junction of Route #4 and Military Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County:
City or town: Plainfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. 452 W 9th Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Earl H. Newberry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 7, 1925

8. AGE: Years	Months	Days	If less than one day
19	5	20	hrs. min.

9. Birthplace: Brooklyn N. Y.
(Town, county, and state)
10. Usual occupation: U.S. Navy
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: U.S. Navy Records
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year)
Cemetery or crematory: W.W. Chapman Cemetery Co.
Location: 1400 Chapin St. N.W. Wash. D.C.

18. Funeral director: W. W. Chamber Co.
Address: 1400 Chapin St. N.W.

19. Feb 27 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 19 45, at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2-27-45
Where did injury occur? Forestville (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route #4
Means of injury: Car on car Injured at work? Yes

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Forestville Md. Date signed: 2-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

01996

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Leland Memorial

How long in hospital or institution? Dead on Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town East Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5300 - Gallatin

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Great Alvin Newman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Eva Newman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1890

8. AGE: Years 54 | Months 8 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Williamsport Pa (Town, county, and state)

10. Usual occupation Taxi Driver

11. Industry or business

FATHER 12. Name Walter B. Newman

13. Birthplace Pa

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Eva Newman

Address 5300 - Gallatin Street, East Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-45 (month) (day) (year)

Cemetery or crematory Wash. Nat. Cemetery

Location Lyttsville md.

18. Funeral director W.W. Chambers Co

Address Riverdale md

19. Feb 17 19 45 (Date rec'd by registrar)

James Severe Registrar

By R.S.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 19 45 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to extereal causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner. James J. Lord M. D. (or other)

Address Forestville md Date signed 2-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

01997

108

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 245

Village or City Greenbelt No. 23 N Ridge Road St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 8 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Timothy O' Herron If U. S. Veteran, specify WAR

(a) Residence: No. 23 N Ridge Road St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna M. Holleron

6. DATE OF BIRTH (month, dey, end year) June 26, 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
85	85	7	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. Driller

9. Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc. Oil and Gas fields

10. Date deceased last worked at this occupation (month and year) 1920

11. Totel time (years) spent in this occupation 45 years

12. BIRTHPLACE (city or town) Pittsburg
(State or country) Pennsylvania

FATHER

13. NAME Michael O'Herron

14. BIRTHPLACE (city or town) Ireland
(State or country)

MOTHER

15. MAIDEN NAME Mary Mc Nally

16. BIRTHPLACE (city or town) Ireland
(State or country)

17. INFORMANT Mrs. J.J. McKinney
(Address) Chicago, Illinois

18. BURIAL, ~~CREMATION~~, OR REMOVAL
Piece Canonsburg Pa Dete 2/8, 1945

19. UNDERTAKER W W Chambers Co
(Address) Riverdale Md.

20. FILED Feb. 8, 1945 Mrs. Jas. Beverage Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February 8 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from January 27, 1945, to February 8, 1945

I last saw him alive on February 6, 1945; death is said to have occurred on the date stated above, at 2.45 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	2-5-45
cerebral arteriosclerosis	15 years

Other **Contributory Causes** of importance:

General arteriosclerosis	15 yrs

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Hans Wrdale M. D.

(Address) 300 Bridge Rd, Greenbelt, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01998

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 7 M 20 D
Hospital, Institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 0 yr. 7 M. 20 D

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Everett (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Amelia B. Ott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife:
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 7 - 1866

8. AGE: Years	Months	Days	If less than one day
78	3	27	hrs. min.

9. Birthplace: Everett, Bedford Co., Penna (Town, County, and state)
10. Usual occupation: Bank Clerk
11. Industry or business:

FATHER
12. Name: Daniel B. Ott.
13. Birthplace: Penna.

MOTHER
14. Maiden name: Martha Miller
15. Birthplace: Penna.

16. Informant: Sanitarium Records
Address: Laurel San., Laurel, Maryland

17. removal (Burial, cremation, or removal. Which?) Date thereof: Feb 3-45 (month) (day) (year)
Cemetery or crematory:
Location: Everett Penna
18. Funeral director: Lloyd Larsen
Address: Laurel Md.

19. February 3 1945 (Date rec'd by registrar) Cora E. Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1945, at 1.45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 14 1944 to Feb. 3 1945 and that I last saw h.. alive on February 1 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage 7 AM	1/31/45
Due to: General Arteria Sclerosis	4 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L Wetherell M. D. (M. D. or other)
Address: Laurel San., Laurel, Maryland Date signed: 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on
FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-a

01999

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Cheverly Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
5 hrs. 10 mins.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Brentwood (If outside city or town limits, write RURAL and give nearest town)
Street No. 3608 Taylor St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Papthanasidys, Apostle
3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Rosary Papthanasidys
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 1 8196

8. AGE:

Years	Months	Days	If less than one day
48 ~~49~~	8	2	... hrs. ... min.

9. Birthplace: Greece (Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business
FATHER — 12. Name: Papthanasidys, Spiro
13. Birthplace: Greece
MOTHER — 14. Maiden name: Pathon, Victoria
15. Birthplace: Greece
16. Informant: Rosary Papthanasidys (wife)
Address: 3608 Taylor St., Brentwood Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 4, 1945 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location
18. Funeral director: S. H. Hines Co.
Address: Washington, D.C.
19. Feb. 4 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1945, at 8:05 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1942, to Feb 3 1945
and that I last saw h... alive on Feb 3 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	5 hours
Due to: Hypertensive cardiac disease	several years
Due to: arteriosclerosis	several years
Other conditions: Previous hemiplegia	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Henry G. Hadley M. D. or other
Address: 1252 ... St. S.W. Wash. D.C. Date signed: Feb 4 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02000

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs., 1 mo., 4 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 yrs., 1 mo., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3411 Q. St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: (MRS) THELMA PENNIFIELD

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: James Pennifield
8.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 8, 1915

8. AGE: Years	Months	Days	If less than one day
29	8	3	..... hrs. ..... min.

9. Birthplace: Roundhill, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Milton Abell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Payne
15. Birthplace: Virginia

18. Informant: Decedent.
Address:

17. Removed to (Burial, cremation, or removal. Which?) Date thereof: Feb 11, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: W. W. Chambers Co
Address: 81st & M Sts. N.E.

19. Feb. 11, 1945 (Date rec'd by registrar) Rowland L. Phillips Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 1945, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1938, to Feb 11 1945 and that I last saw her alive on Feb 11 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	7 yr 3 mo 10
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 2-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

02001

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Geo
City or town: Lakeland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md. County: Pri Geo
City or town: Berwyn P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4802 Navahoe ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mellie Wilhemina Potts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: William Lucius Potts
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Dec 26 1896

8. AGE: Years: 48 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Marion, N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: albert mc Ferren
13. Birthplace: ala.
MOTHER 14. Maiden name: alice Greenlee
15. Birthplace: N.C.
16. Informant: Wm Potts
Address: Berwyn md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 21-1945 (month) (day) (year)
Cemetery or crematory: Washington DC
Location:
18. Funeral director: W. Ernest Jarvis
Address: 1432 4th nw Wash DC
19. Feb 21 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21 1945, at 9:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to Feb 21 1945 and that I last saw her alive on Feb 20 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	6 days
Due to: Hypertension	4 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W S Hudson, M.D.
M. D. or other
Address: Laurel, md. Date signed: Feb 21, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BSF)

02002

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George Hospital
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 days
Hospital, Institution, or street address where death occurred:
Prince Geo. Hospital
How long in hospital or institution? 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State 4102 72 Ave County Prince Geo.
City or town Landover Hills, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rassano Mrs. Minnie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1876

8. AGE: Years	Months	Days	If less than one day
68	9		..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

FATHER
12. Name Frank Chiodo
13. Birthplace Italy

MOTHER
14. Maiden name Jennie Colicco
15. Birthplace Italy

16. Informant Mrs. Mary Philpat - Daughter
Address 4102 - 72 Ave, Landover Hills, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)
Cemetery or crematory Washington, D.C.
Location

18. Funeral director J. H. Rines Co
Address 2901 - 14 St N.W.

19. 2/16/45 19.... Amanda Denney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945 at 5.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1944 to February 16 1945 and that I last saw h... alive on Feb. 15 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	50 days
Due to Generalized Arteriosclerosis	1 year
Due to	
Other conditions Right hemiplegia	50 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward M. Layne M. D. or other
Address Mt. Rainier Md. Date signed 2/16/45

Evidence for change of year of birth of deceased is shown on FILM No G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146a)

CERTIFICATE OF DEATH

02003

Reg. Diat. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long to above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 16 hr 49 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md D.C. County:
City or town: Washington DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6257 Walkermill Rd. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Radtke, Mrs Elsie

3.(b) Social Security Number:

4. Sex: female | 5. Color or race: white | 8.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: John Radtke
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 15 1914

8. AGE: Years: 30 | Months: 1 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Davis
13. Birthplace: D.C.

MOTHER
14. Maiden name: Annie A Healey
15. Birthplace: Washington D C

16. Informant: John Radtke
Address: 6257 Walkermill Rd. S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-1945 (month) (day) (year)
Cemetery or crematory: Memorial Cemetery
Location: Forestville Md.

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S.E. Wash. D.C.

19. Feb 1 1945 (Date rec'd by registrar) Amanda Denny Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-31 1945 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-31 1945, to 2-1 1945
and that I last saw h-- alive on 2-1 - 1945

Immediate cause of death	DURATION
Acute hemorrhagic anemia	16 hrs.
Due to: Central placenta previa	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Central placenta previa
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Francis Lowry M.D.
M. D. or other
Address: 1746 K St. N.W. Date signed 2-1-1945

Body released to Prince George General Hospital by authority of Dr. Boyd ~~was~~ by telephone call to Superintendent 2/1/45

G.K. Besley

M

The correct age is especially important. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

020004

(131a)

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 5 mo. 14 da.
Hospital, institution, or street address where death occurred: Sacred Heart Home
How long in hospital or institution? 3 yrs. 5 mo. 14 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3228 H[illegible]att Pl. N.W (If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Louisia M. Schmitz
3.(b) Social Security Number: No

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 30-1858

8. AGE: Years 86 Months 6 Days 17 If less than one day: hrs. min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Ernest Schmitz
13. Birthplace: Germany

MOTHER
14. Maiden name: Victorine Koenig
15. Birthplace: Germany

16. Informant: Sacred Heart Home Records
Address: Hyattsville, MD

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 2-20-45 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.

18. Funeral director: Francis J. Collins
Address: 3821-14th St. NW. Wash. D.C.

19 Feb. 19, 1945 (Date rec'd by registrar) James Severe By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1943, to Feb 17 1945,
and that I last saw h[er] alive on Feb. 17 1945

Immediate cause of death: Arterio sclero nephro [illegible] — DURATION: 2 yrs.
Due to:
Due to:
Other conditions: Acute dilatation of heart (Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
Address: 35 N.Y. Ave. Date signed: Feb. 17/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

02005

1. PLACE OF DEATH (187)

County Prince Georges Registration Dist. No. 245

Village or City Hyattsville 2nd No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town whara death occurrad yrs. mos. ds. How long in U.S. if of foraign birth? yrs. mos. ds.

2. FULL NAME Eliza I. Siler

(a) Residence: No. 7010 Varnum St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Siler

6. DATE OF BIRTH (month, day, and year) Jan 20, 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total tima (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) No. Carolina

FATHER

13. NAME Thomas W Mathews

14. BIRTHPLACE (city or town) (State or country) N. Carolina

MOTHER

15. MAIDEN NAME Polly Dorsett

16. BIRTHPLACE (city or town) (State or country) No Carolina

17. INFORMANT (Address) Jamy S Barley 7010 Varnum.

18. BURIAL, CREMATION, OR REMOVAL Place Ft Lincoln Date Mar 1, 1945

19. UNDERTAKER (Address) Deal Funeral Home 4512 Ga Ave. N.W.

20. FILED Feb. 26, 1945 James Swem By R.S.S. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 26 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1945, to Feb 26, 1945

I last saw her alive on Feb 25, 1945; death is said to have occurred on the date stated above, at 6:00 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Myocardial failure	6 wks
Bronchopneumonia	3 days

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was thara an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also tha following:

Accidant, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or Injury in any way related to occupation of deceased?

If so, specify

(Signed) John P. Clum M. D.

(Address) Hyattsville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH PENDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As prineipal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The **principal cause of death** and related causes of importance were as follows:	Date of onset	The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		**Other contributory causes of importance:**	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02006

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mos., 12 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 2 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1829 - 6th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Louise Skinner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Calvin Skinner
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): August 18, 1918

8. AGE: Years	Months	Days	If less than one day
26	6	8	....hrs. ....min.

9. Birthplace: Eckman, West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: –

FATHER
12. Name: Samuel Coger
13. Birthplace: Rocky Mt., Virginia

MOTHER
14. Maiden name: Lula Basham
15. Birthplace: Rocky Mt., Virginia

16. Informant: Decedent
Address

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: Feb 28-1945 (month) (day) (year)

Cemetery or crematory
Location: Washington D.C.

18. Funeral director: Thomas Frazier Co
Address: 389 P.S. ave. n.w. Wash. D.C.

19. Feb 26 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26 1945 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14, 1944, to Feb. 26 1945
and that I last saw h. alive on Feb. 26 1945

Immediate cause of death	DURATION
Spontaneous pneumothorax	Hrs. 6 Min.
Pulmonary Tuberculosis	3 Yrs 11 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

012007

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Beverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5607 - 35th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Loretta Spitzig

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 14, 1944

8. AGE: Years: 0 | Months: 4 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Francis Albert Spitzig

FATHER — 13. Birthplace: Cleveland O.

MOTHER — 14. Maiden name: Eleanor Lewis

MOTHER — 15. Birthplace: Richmond Va

16. Informant: Mrs Eleanor Spitzig

Address: Hyattsville Md R 8

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)

Cemetery or crematory: Mt. Oliver Cemetery

Location: Wash - D.C.

18. Funeral director: W W Chapelles Co

Address: Riverdale, Md.

19. Feb 11 1945 Mrs Jas Devere (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Smothering in bed clothing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 2-9-45

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury: smothered in bed clothes Injured at work? No

23. SIGNATURE: James J. Lord, Deputy Medical Examiner M. D. or other

Address: Forestville Md Date signed 2-9-45

VS-A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (EE)

02008

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 45 D. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: John Strong

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (sep.)

6.(b) Name of husband or wife: Hattie M. Strong
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 15, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	3	...hrs. ...min.

9. Birthplace: Charlotte, North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: –

FATHER
12. Name: Joseph Strong
13. Birthplace: Charlotte, North Carolina

MOTHER
14. Maiden name: Mariah, St. Lewis
15. Birthplace: Charlotte, North Carolina

19. Informant: Decedent.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)
Cemetery or crematory: District of Columbia Morgue
Location: Washington D. C.
18. Funeral director: Glenn Dale Sanatorium –
Address: Glenn Dale Md.

19. Feb. 18, 1945 (Date rec'd by registrar) Rowland S. Phillips Dep. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18, 1945, at 2 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9, 1945, to Feb 18, 1945, and that I last saw h.. alive on Feb 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yr 8 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 2.18.45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Suitland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Suitland, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4762 Holmes Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3. (a) FULL NAME: Obediah Swindell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	7			

9. Birthplace: Wilmington N. C. (town, county, and state)

10. Usual occupation: Chauffeur and fireman

11. Industry or business:

FATHER — 12. Name: Do not know

13. Birthplace: " " "

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant: Sister-in-law Alpha F. Fears

Address: 921 R St., N.W.

17. (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Arlington Nat'l.

Location:

18. Funeral director: Thomas Frazier

Address: 389 R. I. Ave. N.W.

19. Feb. 11, 1945 (Date rec'd by registrar) Kenneth Sommer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 1945; at 7.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1945 to Feb 10 1945

and that I last saw him alive on Feb 8 1945

Immediate cause of death	DURATION
Acute Myocardial Decompensation	1 hr
Due to: Acute Bronchopneumonia	20 days
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul E. Van Valtz M. D. or other

Address: Washington 19 DC Date signed: 2/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

02010

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (Rural) Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 27 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.: National Training School (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MARY Ida TAYLOR

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

B.(b) Name of husband or wife: -

6.(c) If olive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1, 1927

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18	-	16		

9. Birthplace: Portsmouth, Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Jordon Taylor

13. Birthplace: ?

MOTHER — 14. Maiden name: Mary Moore

15. Birthplace: Rocky Mount., N. Carolina

18. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Feb 17, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington. D C

18. Funeral director: Henry S. Washington & Sons

Address: 467 L n St. N.W.

19. Feb 17, 1945 (Date rec'd by registrar) Rowland D. Phillips, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1945, at 12 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/21/44 to 2/19/45 and that I last saw her alive on 2/19/45.

	DURATION
Immediate cause of death: Pulmonary tuberculosis	4 MO 1 wk
Complication: Syphilis	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare MD (M. D. or other)

Address: Glenn Dale Md. Date signed: 2/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-7)

02011

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 28 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 128 Brown Ct. S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: THOMAS, JOHN LEO

3. (b) Social Security Number: 577-22-1013

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): April 17, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	8	..... hrs. ..... min.

9. Birthplace: Tompkinsville, Maryland
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: –

FATHER
12. Name: Joseph Thomas
13. Birthplace: Tompkinsville, Maryland

MOTHER
14. Maiden name: Mary Jerdon
15. Birthplace: Tompkinsville, Maryland

16. Informant: Decedent.
Address

17. (Burial, cremation, or removal. Which?) Removal to Date thereof (month) Mar. (day) 2, (year) 1945

Cemetery or crematory

Location: Washington, D.C.

16. Funeral director: Robert F. McGuire

Address: 1820-9th St. N.W.

19. Feb. 25, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25, 1945, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/28 1944 to 2/25 1945 and that I last saw him alive on Febr 25, 1945

Immediate cause of death	DURATION
pulmonary tuberculosis	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other

Address: Glenn Dale, Md. Date signed 2/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

02012

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4½ months
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 4½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Friendly
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8516 Allentown Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alvin Thorne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mrs. Mabel Thorne.
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 30, 1902.

8. AGE:

Years	Months	Days	If less than one day
42	9	3	____ hrs. ____ min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: laborer.
11. Industry or business: Nursery Plant.

FATHER
12. Name: John W. Thorne.
13. Birthplace: md.

MOTHER
14. Maiden name: Frances Rawlins
15. Birthplace: Md.

16. Informant: Mrs. Mabel Thorne.
Address: 8516 Allentown Rd Friendly, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 2-45 (month) (day) (year)
Cemetery or crematory: St John's
Location: Broad Creek Md
18. Funeral director: Thomas F. Murray
Address: 2007 Nichols ave. S.E.

19. Feb. 27 19 45 (Date rec'd by registrar)
James Lewis By R.S.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febry 27th 19 45 at 2.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4th 19 44 to Febry 27th 19 45 and that I last saw h.. alive on Febry 24th 19 45

Immediate cause of death: Congestive Heart Failure — DURATION
Vegetative Mitral Endocarditis
Due to: Bacterial Endocarditis (sub-acute)
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Leslie French M.D. M. D. or other
Address: 215 NEW MEDICAL BLDG 1726 EYE ST. N.W. WASH. D.C. Date signed 2/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-a)

02013

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Lanham Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Lanham, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes Elizabeth Washington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	Married

6.(b) Name of husband ~~or wife~~: Claude Washington

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 11, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	16	hrs. min.

9. Birthplace: Mitchellville, Prs. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Isaac Mitchell
13. Birthplace: Mitchellville, Prs. Co. Md.

MOTHER
14. Maiden name: Henrietta Fletcher
15. Birthplace: Mitchellville Prs Co Md.

16. Informant: Helen Mitchell (sister-in-law)
Address: Mitchellville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 27 45 (month) (day) (year)

Cemetery or crematory: Mitchellville

Location: Prince George Md.

18. Funeral director: George H. Shade

Address: Wayside Md.

19. Feb. 27 (Date rec'd by registrar) 1945 Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27, 45 at 9:40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 28 19 45, to Feb 27 19 45
and that I last saw h.e.r alive on Feb. 26 19 45

Immediate cause of death: Acute Myocarditis — DURATION: 1-month

Due to: Nerve Irritation + Overworked Heart muscle — DURATION: ?

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. H. Speller M.D.
M. D. or other

Address: Brentwood Md. Date signed 2-27-45

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02014

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

1212 - 59th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1212 - 59th

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Webster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Edward J. Webster

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Feb 4, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	24	....hrs. ....min.

9. Birthplace: Prince George County Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: James Mangum

13. Birthplace: Maryland

MOTHER

14. Maiden name: Nalley

15. Birthplace: Maryland

16. Informant: John Mackie

Address: 1202-61st Ave, Capitol Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-45 (month) (day) (year)

Cemetery or crematory: Episcopal Church

Location: Forestville Md.

18. Funeral director: W. W. Chambers Co

Address: 517 11th St S.E.

19 Feb. 28, 1945 (Date rec'd by registrar) Carrie F. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Toxemia	
Due to: Repeated vomiting, intestinal obstruction	
Due to: Strangulated right inguinal hernia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James S. Young Deputy medical Examiner. M. D. or other

Address: Forestville Md. Date signed: 2-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02015

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Place Prince George
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lanham & Severn Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Cleveland Wesley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Anna Wesley Deceased 6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Febr 15 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	11	17		

8. Birthplace: maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Penn R R Co
FATHER — 12. Name: James Wesley
FATHER — 13. Birthplace: Md
MOTHER — 14. Maiden name: Christiana Phelps
MOTHER — 15. Birthplace: Md
16. Informant: Annie M. Mallonee
Address: Lanham, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-45. (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Rd, Md.
18. Funeral director: F. Gaeta Sons
Address: Hyattsville Md.
19. Feb 3 1945 (Date rec'd by registrar) Mrs Jack Barrett D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1 19 45 at 1650 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 45 to Feb 1 19 45 and that I last saw him alive on Feb 1 19 45

Immediate cause of death	DURATION
Coronary Embolism	8 hrs
Due to: Arteriosclerosis	4 yrs +
Due to: age	
Other conditions: Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H B Montgomery M. D. or other
Address: Lanham Date signed Feb 3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02016

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr. 15 min

Hospital, institution, or street address where death occurred: Warren Hospital

How long in hospital or institution? 1 hr. 14 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George

City or town Laurel, Route 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charlotte ~~Baby~~ Ann Girl Wessel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	

6.(b) Name of husband or wife Roland Frederick Wessell

7. Birth date of deceased (mo., day, yr.) Feb. 14 1945 6.(c) If alive, give age ..... years

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 14 min.

9. Birthplace Laurel, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Roland Frederick Wessell

13. Birthplace Laurel, Howard Co. Md.

MOTHER 14. Maiden name Dorothy Elizabeth Lathiel

15. Birthplace Laurel, Howard Co.

16. Informant Roland F. Wessell

Address Laurel — Fulton Rfd

17. Burial (Burial, cremation, or removal (Which?)) Date thereof Feb 15 1945 (month) (day) (year)

Cemetery or crematory St. Paul Cemetary

Location Fulton Md.

18. Funeral director De Witt Donaldson

Address Laurel Md

19. Feb 15 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 14 1945 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 14 1945 to 2 14 1945

and that I last saw h alive on 2 14 1945

Immediate cause of death	DURATION
Blue Baby	
Premature Birth	
Due to Maternal Obesity	
Due to Nephritic Toxaemia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B C Warren M. D. or other

Address Laurel Md Date signed 2 14 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02017

Reg. Dist. No. 2-45-24

1. PLACE OF DEATH:
County: Prince George's Co.
City or town: Parkham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Princess Garden Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Parkham
(If outside city or town limits, write RURAL and give nearest town)
Street No. Princess Garden St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nellie Cordia White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank H. Deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 7, 1861

8. AGE: Years: 84 | Months: 0 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Beckett
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Frank B White (Son)
Address: Parkham, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/6/45 (month) (day) (year)

Cemetery or crematory
Location 57-11th S.E.

18. Funeral director: Beauchamp & Beauchamp
Address: Rockville Md

19. Feb. 6 1945 (Date rec'd by registrar) Mrs. Jas. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945, at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 1945 to February 1 1945
and that I last saw h.. alive on January 31 1945

Immediate cause of death	DURATION
arteriosclerosis	7 yrs
Due to: Senility	7 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury Injured at work?

23. SIGNATURE: John D Larson Jr M.D. M. D. or other
Address: Bowie, Md. Date signed Feb 1 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02018

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: MOUNT RAINIER
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 YEARS
~~Hospital, institution, or~~ street address where death occurred:
4006 - 31st Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEORGES
City or town: MOUNT RAINIER
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4006 - 31st Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Priscilla Adams Withers

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband ~~or wife~~: JAMES Edgar Withers
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 29, 1855

8. AGE: Years	Months	Days	If less than one day
89	9		...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business: NONE

FATHER
12. Name: William Jerman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret Heath
15. Birthplace: Virginia

16. Informant: J. Robert Sherwood
Address: 4014-31st St. Mt. Rainier, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 3, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Methodist Cemetary
Location: Arlington, Virginia

18. Funeral director: Gasch's Sons Funeral Home
Address: Hyattsville, Maryland

19. March 1 19 45 (Date rec'd by registrar) James Bowers By R.S.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 28 19 45, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 19 45, to Feb. 28 19 45
and that I last saw h... alive on Feb. 28 19 45

Immediate cause of death	DURATION
Arteriosclerosis	7 yrs
Chronic Nephritis	
Due to: Senility	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.
M. D. or other
Address: 3203 Rang 4 Mt Rainier Date signed: 2-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02019

93rd

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Mother Joseph Rest Home
How long in hospital or institution? 1 yr 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co.
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4404 Tuckerman st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: David Joel Witter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Minerva A Witter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 6, 1872.

8. AGE: Years	Months	Days	If less than one day
72	2	15	..... hrs. ..... min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Insurance Agent
11. Industry or business:
FATHER 12. Name: David Witter
13. Birthplace: Virginia
MOTHER 14. Maiden name: Hettie Tippy
15. Birthplace: Maryland
16. Informant: Calvin Witter
Address: University Park Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23, 1945 (month) (day) (year)
Cemetery or crematory: Rhoades Cemetery
Location: Westminster Md.
18. Funeral director: F Gaschi sons
Address: Hyattsville Maryland
19. Feb 22 1945 (Date rec'd by registrar) Mary Jo Reeves Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21, 1945, at 2 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944 to February 21 1945 and that I last saw h.... alive on Nearly 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Several Years
Due to Arteriosclerosis	Several Years
Due to Senility	Several Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Wm Allen Griffith M. D. of other
Address: Berwyn Md Date signed 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02020

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 317- 15th St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: JAMES. D. WOOLEN

3.(b) Social Security Number: 578-26-3183

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1901

8. AGE: Years	Months	Days	If less than one day
43	8	14	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Florist Shop Employee

11. Industry or business: —

FATHER
12. Name: James Boyd Woolen
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alice ?
15. Birthplace: Virginia

16. Informant: Decedent.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Robinson Co.

Address: 1342 - 4th St N.W.

19. Feb 21 1945 (Date rec'd by registrar) Rowland D. Perkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 21st 1945 at 6 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20th 1944, to Feby 21st 1945 and that I last saw him alive on Feby 21st 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 2/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02021

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County Prince Georges
City or town North Keys
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town North Keys
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Alfred Wright

3.(b) Social Security Number

4. Sex Male
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Wilhelmina Wright
6.(c) If alive, give age 20 years
7. Birth date of deceased (mo., day, yr.) March 7, 1923
8. AGE: Years 21 Months Days If less than one day ... hrs. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm
FATHER 12. Name Earnest Wright
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Curtis
15. Birthplace Maryland
16. Informant Earnest Wright
Address North Keys, Md
17. Burial (Burial, cremation, or removal (Which?)) Date thereof Feb 12 1945 (month) (day) (year)
Cemetery or crematory St Phillips Church
Location Aquasco Md.
18. Funeral director A. J. Grimes
Address Aquasco, Md
19. Feb 10 1945 (Date rec'd by registrar) Ernest H Garner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945 at 4 30 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Acute pulmonary edema	
Due to Congestive heart failure	
Due to Hypodermic injection ? novocain to extract tooth	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of 2-8-45
Where did injury occur? Brandywine P. G. Co. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Dentist's Office
Means of injury Intra muscular [illegible] Injured at work? No
Deputy Medical Examiner
23. SIGNATURE James H Day M. D. or other
Address Forestville Md Date signed 2-9-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02022

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 6 mos., 4 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 yrs., 6 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 61 Randolph Place N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: EDWIN JOSEPH YERAK

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1912

8. AGE:

Years	Months	Days	If less than one day
32	7	12	..... hrs. ..... min.

9. Birthplace Minneapolis, Minnesota
(Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business

FATHER
12. Name Rudolph Yerak
13. Birthplace Czechoslovakia

MOTHER
14. Maiden name Maggie Holisky
15. Birthplace Czechoslovakia

16. Informant Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Feb. 20, 1945 (month) (day) (year)
Cemetery or crematory
Location Washington, D.C.
18. Funeral director J. F. Costello
Address 1722 North Capitol St. Wash. D.C.
19. Feb 20 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945 at 8:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1938, to February 20 1945 and that I last saw h. alive on February 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 years 7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pincane M.D.
M. D. or other
Address Glenn Dale, Md. Date signed 2/20/45

M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM # G 94 APR 13 1945

012123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-F)

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Pr. George
City or town Hyattsville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred: 5208-42 ave Hyattsville md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Justine Marie Zyvoloski (Zywiolowski) **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Albert J. Zyvoloski
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept-26-1892

8. AGE: Years	Months	Days	If less than one day
52			hrs. min.

9. Birthplace Little Falls. Minn. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Anton Kozial
13. Birthplace Poland
MOTHER 14. Maiden name Mary Sequilka
15. Birthplace Poland
16. Informant Albert J. Zyvoloski
Address 5208-42 Ave Hyattsville md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-45 (month) (day) (year)
Cemetery or crematory Arlington Natl. Cemetery
Location Fort Myer Va
18. Funeral director Lowe Chambers Co
Address Riverdale md
19. Feb. 12 1945 (Date rec'd by registrar) Mary E. Miner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945 at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1944, to Feb. 10 1945
and that I last saw h alive on February 8 1945.

Immediate cause of death	DURATION
Generalized Carcinomatosis of	
Due to all bones of body	
Due to Primary Lung Carcinoma of Uter	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Hyattsville md Date signed 2-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15